Mr. Andrew Yaxley

# A P Yaxley Dental Surgery

## Inspection Report

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## Overall summary

We carried out this announced inspection on 2 July 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

**Our findings were:**

**Are services safe?**

We found this practice was not providing safe care in accordance with the relevant regulations.

**Are services effective?**

We found this practice was providing effective care in accordance with the relevant regulations.

**Are services caring?**

We found this practice was providing caring services in accordance with the relevant regulations.

**Are services responsive?**

We found this practice was providing responsive care in accordance with the relevant regulations.

**Are services well-led?**

We found this practice was not providing well-led care in accordance with the relevant regulations.

**Background**

A.P. Yaxley is a well-established dental practice based in Lowestoft that offers NHS general treatment to both children and adults. Another provider is located at the same address, and although registered separately, they both operate as one service, with shared expenses, staff and governance arrangements.

The dental team consists of a dentist, three dental nurses, and two receptionists (who are also shared with the other dentist located on the premises). There are two treatment rooms. The practice opens on Mondays to Fridays from 9 am to 5.30 pm.

# Summary of findings

There is level access for wheelchair users and on street parking close by.

The practice is owned by an individual who is the dentist there. He has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we collected 49 CQC comment cards filled in by patients and spoke with another three.

During the inspection we spoke with the dentist, two nurses and the receptionist. We also spoke with three patients. We looked at practice policies and procedures and other records about how the service is managed.

**Our key findings were:**

- Staff treated patients with dignity and respect, and we received many positive comments from patients about the caring and empathetic nature of the dentist.
- The practice was small and friendly, something which both patients and staff appreciated.
- The practice appeared clean and well maintained.
- Infection control procedures reflected published guidance and legionella was managed well.
- The appointment system met patients' needs and patients could get an emergency appointment easily.
- Patient dental care records did not reflect standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- The management of risk in the practice was limited and identified hazards had not been managed adequately.
- The dentist did not into account guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's own homes.
- Staff did not receive a regular appraisal of their performance or training needs
- Governance procedures were not robust and audit systems were not effective in driving improvement.

We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

**Full details of the regulations the provider was not meeting are at the end of this report.**

There were areas where the provider could make improvements. They should:

- Review the practice's protocols for the use of dental dams for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review staff understanding of the Mental Capacity Act and Gillick competency guidelines so that they are aware of their responsibilities in relation to them.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**
We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

**Requirements notice** ✖

**Are services effective?**
We found this practice was providing effective care in accordance with the relevant regulations.

**No action** ✓

**Are services caring?**
We found this practice was providing a caring service in accordance with the relevant regulations.

**No action** ✓

**Are services responsive to people's needs?**
We found this practice was providing responsive care in accordance with the relevant regulations.

**No action** ✓

**Are services well-led?**
We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

**Requirements notice** ✖

# Are services safe?

## Our findings

**Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays))**

The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Information about local protection agencies was displayed on the staff noticeboard, making it easily accessible. However, there was no named lead in the practice for safeguarding and not all staff had received regular safeguarding training. The dentist had not undertaken any training in the protection of vulnerable adults since 2009.

We found that the dentist did not always use dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. Alternative methods used to protect patients' airway were not recorded in the patients' notes. There was no formal written protocol in relation to safety standards for invasive procedures. The practice had a business continuity plan describing how it would deal with events that could disrupt its normal running. This was kept off site, so it could be accessed in the event of an incident.

The practice had a recruitment policy in place, however this was dated 2012 and had not been updated to reflect current guidance. We viewed the personnel files for two staff and noted one had recently been employed without any references having been obtained.

The practice had undertaken a fire risk assessment and had installed illuminate fire exit signage and alarms as a result. However, we noted that there had been no recorded fire drills for since 2016. One member of staff told us they had never practiced evacuating the building since she started her employment at the practice in 2018. The dentist had not undertaken any fire safety training since 2011. We noted a large number of cardboard boxes in the upstairs area of the practice, which could be highly combustible in the event of a fire.

The provider had some risk assessments in place for the control of substances that were hazardous to health (COSHH). However, it was not clear when they had been reviewed, and there were no product safety information sheets for the materials used.

The practice had some arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. However, there was no rectangular collimation on the X-ray units to reduce patient exposure.

**Risks to patients**

A general risk assessment had been completed for the practice, but its recommendations to visually inspect electrical equipment every six months, to use rubber dams and for staff to have moving and handling training, had not been implemented. A risk assessment had not been completed for one pregnant member of staff, and for another who had not yet received their Hep B booster vaccination.

The dentist was not using the safest types of needles to prevent injury. A specific sharps risk assessment had been undertaken but was limited in scope. It only identified risks in relation to the use of needles and did not include other instruments such as matrix bands, scalpels and scissors.

The dentist visited some patients in their homes to undertake basic dental treatment. However, there were no policies or protocols in place in relation to these visits, the dentist did not take any emergency medical equipment with them and no risk assessment was completed prior to the visit. It was not clear if adequate insurance was in place.

Staff had completed yearly training in resuscitation and basic life support, although did not regularly rehearse emergency medical simulations so that they had an opportunity to practise their skills. Most emergency equipment and medicines were available as described in recognised guidance, apart from child ambu-bags and facemasks.

We noted that all areas of the practice were visibly clean, including the waiting area, toilet and staff area. We checked both treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. We found uncovered instruments in treatment room drawers that risked aerosol contamination. The dentist routinely worked without chair side support three days a week. He also undertook visits to patients in their own home without a nurse in attendance. This was not in line with General Dental Council (GDC) Standards for the Dental Team

# Are services safe?

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

Systems were in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. All staff uniforms were laundered on site.

The practice had effective procedures to reduce the possibility of Legionella or other bacteria developing in the water systems and an external contractor had been employed to maintain the water quality within the premises.

**Safe and appropriate use of medicines**

Staff were aware of the yellow card scheme for reporting adverse reactions to drugs or defective medicines. The fridge's temperature, in which Glucagon was kept, was monitored to ensure it operated effectively.

NHS prescription pads were not held securely and there was no tracking in place to monitor individual prescriptions to identify their theft or loss

An antimicrobial audit had not been undertaken to assess if the dentist was prescribing according to national guidance. We found that the dentist was routinely prescribing a longer course of antibiotics that the guidance recommends.

**Lessons learned and improvements –**

We found that staff had a limited understanding of what might constitute an untoward event and were unclear about national reporting requirements. We noted several incidents recorded in the accident book but there was no evidence to show how learning from them had been shared to prevent a recurrence.

There was no system in place to ensure staff received national patient safety alerts. The dentist told us he had not received any alerts since they had ceased sending them in paper format, some three to four years ago.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment, care and treatment**

We received 49 comments cards that had been completed by patients prior to our inspection. The comments received reflected that patients were very satisfied with their treatment and the staff who provided it. They clearly appreciated the continuity of care they had received over the years.

Our review of dental care records indicated that patients' dental assessments and treatments were not always carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC). For example, the findings from intra and extra oral assessments were not always recorded. Patients' social histories, risk of caries, periodontal disease, oral cancer and non-carious tooth loss had not been recorded consistently to inform patient recall intervals. Records were not always legible. The patient consent process was not described with any consistency i.e. with discussions around options, treatment planning etc

No audits of the dental care records had been undertaken to assess their quality and to ensure they met nationally recognised standards.

**Helping patients to live healthier lives**

We found clinicians had a limited understanding and awareness of the Department of Health's guidance, Delivering Better Oral Health toolkit. The dentist told us they gave oral health advice to patients, but dental care records we reviewed did not always demonstrate this.

It was not possible for us to assess how patients' gum disease was manged as basic periodontal examinations were not undertaken to determine the level of treatment they required, or improvements achieved.

**Consent to care and treatment**

Patients confirmed their dentist listened to them and gave them clear information about the treatment.

The practice did not have any specific policies in relation to the Mental Capacity Act (MCA). We found that staff did not have an adequate understanding of and its implications when treating patients who might not able to make decision for themselves. The dentist did not apply its principles when treating patients without capacity during domiciliary care visits. Staff were also unaware of Gillick competence guidance and its implications when treating young people.

**Effective staffing**

We received mixed feedback from staff as to the adequacy of staffing levels at the practice. Some staff told us that, although a small team, there were enough of them for the smooth running of the service. Other staff told us there weren't enough and that a staff member's maternity leave had not been covered.

The dentist worked without a dental nurse three days a week. He had a large NHS contract of 10970 units of dental activity a year.

**Co-ordinating care and treatment**

The dentist told us he referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. The practice also had systems and processes for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice did not actively monitor non-NHS referrals to make sure they were dealt with promptly. Patients were not routinely offered a copy of their referral for their information.

# Are services caring?

## Our findings

**Kindness, respect and compassion**

We received many positive comments from patients about the caring nature of the practice's staff. Patients described staff as friendly, caring and understanding of their needs. One patient told us, 'The staff are 100% caring and have always treated me with great dignity and respect'. Another commented, 'I suffer with sever dental phobia, however Mr Yaxley is a great professional dentist who is empathetic and always acknowledges and takes time to understand my fears'.

Reception staff were described as 'Very pleasant with a very professional and calming manner'

We noted that one staff member showed excellent understanding of Parkinson's' disease and described to us the measure they took to support a patient with this condition.

**Privacy and dignity**

The reception area was not particularly private, but the receptionist told us some of the practical ways they helped maintain patient confidentiality. We noted a poster on display advising patients they could request to speak in a private room if needed. We noted blinds were on the window in the downstairs treatment room to prevent passers-by looking in.

We noted that the treatment room door was kept open whilst a patient was receiving treatment thereby compromising their privacy and confidentiality.

Patients' confidential medical records were stored in open shelves which could not be locked.

**Involving people in decisions about care and treatment**

Patients confirmed the dentist listened to them and gave them clear information about their treatment. One commented, 'Everything about any treatment I require is fully explained and all queries answered'.

However, dental records we reviewed did not always show what treatment options had been discussed with patients, or fully document the consent process.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice had made some adjustments for patients with disabilities. There was level access to the entrance and ground floor treatment rooms. A magnifying glass was available on reception to help those with visual impairments. However, the toilet was not fully accessible and there was no hearing loop to assist patients with hearing aids. Information about the practice was not produced in any other formats or languages, and reception staff were unaware of translation services. The practice did not offer a card payment system, despite staff telling us this was a very frequent request from patients.

**Timely access to services**

At the time of our inspection, the practice was not registering any new NHS patients as it had fulfilled its contractual requirements.

Patients could access care and treatment from the practice within an acceptable timescale for their needs. Staff told us that the waiting time for a routine appointment was about two weeks.

Emergency slots were available each day for patients experiencing dental pain. One patient commented, 'I am offered appointments that fit in around my rigid child care schedule'.

Another stated, 'they always try to fit you in especially if there is an emergency or you are in pain.

Reception staff told us that the dentist was good at running to time and patients rarely waited, having arrived for their appointment. Patients' comments cards we received also reflected this.

The practice participated in the local NHS out of hours 111 service and patients were able to access week-end appointments if needed.

The practice did not have any system in place such as text or emails to remind patients of their appointments.

**Listening and learning from concerns and complaints**

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales and other agencies that could be contacted. Information about how patients could raise their concerns was available in the waiting room, and in a specific complaints' leaflet that could be given to patients.

It was not possible for us to assess how the practice dealt with patients' complaints, as we were informed that none had been received by the dentist in the many years he had worked there.

# Are services well-led?

## Our findings

**Leadership capacity and capability**

Although two dentists worked at the practice providing one service, each was registered with us separately in their own right. Each had overall responsibility for both the management and clinical leadership of the practice. As there was not a dedicated practice manager, one of the dentists had taken on most managerial tasks themselves and it was clear they had struggled to keep on top of administrative and governance procedures.

The practice had not fully prepared for our inspection and staff had failed to gather the evidence we had requested prior to our visit. This made the inspection difficult and we were not able to fully assess some aspects of the service as information was not available to review.

**Culture**

The dentist described the practice as an old-fashioned type family practice. It was small and friendly and had built up a loyal and established patient base. It was clear the dentist knew his patients well and had built up good rapport with many of them over the years.

The practice had a duty of candour policy in place, and staff had a satisfactory knowledge of its requirements.

**Governance and management**

The practice did not have robust governance procedures in place. We found that the dentist worked in relative isolation and had not kept up to date with current dental practices and guidelines. We identified a number of shortfalls during our inspection including the recruitment of staff, the quality of dental care records and the dissemination of national safety alerts which demonstrated that governance procedures in the practice were ineffective.

Although the practice had policies in place, these were very generic, and many had not been reviewed regularly. There was no evidence to show that staff had read, discussed and understood the polices. Risk assessment was limited and identified hazards within the practice that had not been addressed.

Dental care records we saw were not always complete, legible, and were not kept securely.

There were occasional practice meetings involving all staff, which staff told us they found useful.

**Engagement with patients, the public and external partners.**

Prior to our inspection we asked the practice to gather examples of where they had implemented staff and patients' suggestions, however we were not provided with any. Staff we spoke with during our inspection told us that patients had frequently requested radio music to be played in the waiting room and for a card payments system to be introduced. However, their suggestions had not been implemented.

There was a suggestion box in the waiting room and patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. Results showed that all 11 patients who completed the test for May 2019 would recommend the practice.

**Continuous improvement and innovation**

The practice paid for staff's training to help them keep their continuous professional development up to date. However, none of the staff received a regular appraisal so it was not clear how their performance was assessed, or their training needs identified.

The practice did not have robust quality assurance processes to encourage learning and continuous improvement. Audits did not follow national guidance and their results were not effectively analysed and used to drive improvement. There was no evidence of resulting action plans and improvements.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 (1) Good Governance**<br>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br>How the regulation was not being met:<br>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:<br>In particular:<br>· There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.<br>• There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice.<br>· Audits of dental care records, antibiotic prescribing and radiography were not effective in identifying shortfalls and areas for improvement.<br>• Risk assessment was not robust and identified hazards within the practice had not been addressed. |

This section is primarily information for the provider

# Requirement notices

- There was no effective system to ensure the practice's policies and procedures were regularly reviewed and updated.

- There was no system in place to ensure staff received regular appraisal of their performance and to identify any learning and development needs.

**Regulation 17 (1)**

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Regulation 12- Safe Care and Treatment.<br>Care and treatment must be provided in a safe way for service users<br>**How the regulation was not being met**<br>• NHS prescription pads were not held securely, and no system was in place to monitor and track their use.<br>• Guidelines as set out by the British Society for Disability and Oral Health were not followed when providing dental care in domiciliary settings such as care homes or in people's own homes.<br>• Patients' confidential medical notes were not stored securely.<br>• There was no system in place to ensure that national patient safety alerts were disseminated appropriately.<br>• Appropriate pre-employment checks were not undertaken for new staff starting work at the practice.<br>• Fire safety procedures were not managed effectively.<br>Regulation 12 (1) |